

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-028649

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4120 STATE FILE NUMBER

FILED AUG 9 1963

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
Length of stay in 1b 21 yrs.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. General Hospital		d. STREET ADDRESS (If outside, give location) 2920 Forest - Apt. 2	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First WALTER Middle EARL Last SIMPSON			4. DATE OF DEATH Month 7 Day 19 Year 1963		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-5-86	9. AGE (last birthday) 77	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Lineman		10b. KIND OF BUSINESS OR INDUSTRY Standard Oil Co.		11. BIRTHPLACE (City and state or country) Humansville, Mo. U.S.A.	
13a. FATHER'S NAME Rufus Simpson		13b. MOTHER'S MAIDEN NAME Mary Conrad		14. NAME OF HUSBAND OR WIFE Sarah Berry Simpson	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	17. INFORMANT Address Mrs. Sarah Simpson: 2920 Forest, K.C., Mo.
--------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		
DUE TO (b)		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) History Diabetes Mellitus		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	----------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

20c. TIME OF INJURY Hour 6:10 a.m. p.m.	Month, Day, Year
---------------------------------------------------	------------------

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION Centerville	COUNTY Linn	STATE Kansas
--------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------	----------------------------------------------------	--------------------	---------------------

21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 6:10 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

22a. SIGNATURE Hugh H. Owens (Degree or title) M.D. Coroner	22b. ADDRESS 152 Union Station - K.C., Mo.	22c. DATE SIGNED 7-20-63
---------------------------------------------------------------------------------	------------------------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7-22-63	23c. NAME OF CEMETERY OR CREMATORY Centerville Cemetery	23d. LOCATION (City, town, or county) (State) Centerville Linn Co., Kansas
-------------------------------------------------------------	-----------------------------	-------------------------------------------------------------------	--------------------------------------------------------------------------------------

24. FUNERAL DIRECTOR WEILERT FUNERAL HOMES(S) K.C., MO.	25. DATE RECD. BY LOCAL REG. 7-22-63	26. REGISTRAR'S SIGNATURE Ruth Long
-------------------------------------------------------------------	------------------------------------------------	-----------------------------------------------

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

Hugh H. Owens, M.D.

ITEM NO.

DATE AMENDED

VS 300
Rev. 4/59

1

2 3 4 5 6 7 8 9 10 11 12 13

0

1

0

2

94200

923

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Licensed Embalmer No. 4531

P. O. Address Kansas City, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.